ACCIDENT REPORT
EMPLOYEE'S STATEMENT

State Employee Injury Compensation Trust Fund/SEICTF

This form to be completed by the employee and submitted to immediate supervisor on the day the injury occurs. The supervisor should submit the First Report of Injury (SEICTF Form 1) along with this form immediately to: FAX 334 223-6170 or toll-free 888 827-6753.

Name of Employee: _____ Social Security Number: _____

Home Address: _____

Home Phone No.: _____ Employee's Date of Birth: _____

Job Title/Job Classification: _____County of Employment: _____

Date of Injury/Accident: _____ Time of Injury/Accident : _____a.m._____ p.m._____

Date Supervisor Notified: _____

Was accident/injury the result of an automobile accident? _____Yes ____ No
If yes, obtain a copy of police report of accident and submit to supervisor as soon as possible.

Exact location where injury/accident occurred:

_____ _____

Were there any witnesses? If so, give names, addresses and phone numbers.

_____

_____

Describe fully the specific activity you were performing at the time the event occurred and what happened to cause the injury/accident. Indicate the body part(s) affected:

_____

_____

At the time of the injury, were you using any protective equipment (ex. Latex gloves, eye protection)?

_____Yes _____No

Have you had previous treatment for a similar condition or injury to the same body part?

_____Yes _____ No

If yes, enter dates of injuries and name(s) and address of treatment provider(s).

_____

_____

I understand the reporting of false information may disqualify me from receiving SEICTF benefits. I certify the above information is correct to the best of my knowledge.

Signature of Employee: _____

Date: _____

Signature of Supervisor reporting incident: _____

Date received: _____